

Please verify contract benefit information before submission of form.

Precertification for **hospice services** is required prior to **OR** within 5 days of start of care.

NAME OF HOSPICE _____

After initial certification, 30-day review required unless otherwise specified by case manager

PATIENT INFORMATION

Patient Name _____

Patient Address _____

Patient Telephone _____ DOB _____

Name of Contract Holder _____

Primary Caregiver _____ Telephone number _____

Contract Number _____

Secondary Insurance _____

Primary Hospice Diagnosis _____ ICD-10 _____

Secondary Diagnosis _____

Start of Hospice _____

PLACE OF CARE

_____ Home Care _____ Inpatient Hospice _____ Respite: Inpatient Home

SERVICES PROVIDED (indicate all and how often)

_____ SN _____ MSW _____ HHA _____ Chaplain _____ Therapist _____ MD/CRNP

_____ DME: Hospital bed Bedside Commode Oxygen/supplies BiPap Wheelchair Walker/cane Nutritional supplements
IV fluids Wound care Other _____

CLINICAL

Disease-Specific Clinical Information

Heart Disease	Pulmonary Disease	Dementia/Progressive Neurologic	HIV
___ NYHA class 4	___ Dyspnea at rest	___ Unable to walk	___ CD4 count < 25
___ TX: diuretics/vasodilators	___ Right heart failure	___ Dependent in ADLs	___ Viral load > 100,000
___ Cardiac arrest/syncope/cva	___ O2 sat: max O2 support	___ Speech < 6 intelligible words	___ Karnofsky < 40
___ Documented ED visits/adm	___ PCO2 > 55	___ Unintentional weight loss	___ Comorbidities
___ No Transplant option	___ Unintentional weight loss	___ Comorbid conditions	

Liver Disease	Renal Disease	ALS
___ INR > 1.5	___ No Dialysis	___ Karnofsky < 40
___ Albumin < 2.0	___ Cr clearance <10 ml/min	___ Impaired pulmonary status
___ Refractory ascites	___ Serum Cr > 6.0	___ Dysphagia/unable to support life
___ Recurrent variceal bleed		___ Comorbidities
___ Jaundice		
___ Malnutrition/muscle wasting		

Failure to thrive or generalized weakness are not eligible diagnosis for benefit coverage

History and Progression of Disease (attach clinical notes)

(Worsening symptoms, change in mental status, declining physical function, weight loss, etc.)

Vital signs: _____ B/P _____ P _____ R _____ T _____ Ht _____ Wt _____ BMI

Karnofsky score _____ O2 sats Room Air _____ O2 sats max O2 _____

Brief Description: _____

Past Medical History : _____

Progression of Disease: _____

Recent laboratory data and dates: BUN/Cr _____ Albumin _____ Hct/Hgb _____

